NEW JERSEY STATE HEALTH BENEFITS PROGRAM COMPARISON CHART

PLAN AND TELEPHONE NUMBER	#002 TRADITIONAL[1] 1-800-414-7427	#001 - NJ PLUS In-Network 1-800-414-7427	#001 - NJ PLUS Out-of-Network[1] 1-800-414-7427	#019 - AETNA Active 1-800- 309-2386 Retiree on Medicare 1-800-345-4432	#020 CIGNA HEALTHCARE 1-800-244-6224	#028 OXFORD 1-800-760-4566	#033 AMERIHEALTH 1-800-877-9829	#034 HEALTH NET[6] 1-800-441-5741	PLAN AND TELEPHONE NUMBER
SERVICE AREA	Unrestricted	All of NJ, DE, NC and SC; Parts of NY and PA	Unrestricted	All of NJ, CT and DE; Parts of AZ, FL, IL, IN, MD, NY, NC, PA, TX and VA	All of NJ, CT, DE, PA, AZ, SC and Wash. DC; Parts of CA, FL, GA, MD, NY, NC, VA and WV	All of NJ; parts of NY	All of NJ and DE; parts of PA	All of NJ and CT; parts of NY (Parts of PA pending approval)	**SERVICE AREA**
EXPENSES COVERED									**EXPENSES COVERED**
HOSPITAL INPATIENT	100% for up to 365 days; day 366+ at 80% after deductible	100%	70% after $200 per hospital stay deductible	100%	100%	100%	100%	100%	**HOSPITAL INPATIENT**
SKILLED NURSING FACILITY	100% for up to 30 days per confinement	100% for up to 120 days per calendar year	70% for up to 60 days per calendar year	100%; unlimited days	100% for up to 120 days per calendar year	100% for up to 120 days per calendar year	100% for up to 180 days per calendar year	100% for up to 120 days per confinement	**SKILLED NURSING FACILITY**
HOSPITAL PRE-ADMISSION TESTING	100%	100%	70% after deductible	100%	100%	100%	100%	100%	**HOSPITAL PRE-ADMISSION TESTING**
PHYSICIAN (SURGERY)	Basic benefit at 100%[1]; balance at 80% after deductible	100%	70% after deductible	100%	100%	100%	100%	100%	**PHYSICIAN (SURGERY)**
PHYSICIAN (OFFICE VISITS)	80% after deductible; no coverage for wellcare	100% after $5 per visit copayment	70% after deductible; no coverage for wellcare	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	**PHYSICIAN (OFFICE VISITS)**
CHIROPRACTIC	80% after deductible for up to 30 visits per calendar year	100% after $5 per visit copayment; 30 visits per calendar year; no PCP referral required	70% after deductible for up to 30 visits per calendar year	100% for up to 20 visits per year, $5 per visit copayment; PCP referral required	100% for up to 20 visits per year, $5 per visit copayment; PCP referral required	100% after $5 per visit copayment, no visit maximum; PCP referral required	100% for up to 20 visits per year, no copayment; PCP referral required	100% for up to 20 visits per year, $5 per visit copayment; no referral needed	**CHIROPRACTIC**
EMERGENCY ROOM - ACCIDENT/ NON-ACCIDENT	100% for accidental injury; 80% for non-accidental injury after deductible	100% after $25[2] copayment if reported to PCP and/or NJ PLUS within 48 hours	100% after $25[2] copayment if reported to PCP and/or NJ PLUS within 48 hours; if not reported within 48 hours, subject to deductible and coinsurance	100% after $35[2] copayment	100% after $35[2] copayment	100% after $25[2] copayment	100% after $35[2] copayment	100% after $25[2] copayment	**EMERGENCY ROOM - ACCIDENT/ NON-ACCIDENT**
DURABLE MEDICAL EQUIPMENT	80% after deductible	90% reimbursement	70% after deductible	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	**DURABLE MEDICAL EQUIPMENT**
RADIATION/ CHEMOTHERAPY OUTPATIENT	80% after deductible	100%	70% after deductible	100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit	**RADIATION/ CHEMOTHERAPY OUTPATIENT**
IMMUNIZATIONS	Not covered	100% after $5 copayment per visit (except for travel)	70% for children under 12 months, after deductible	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	**IMMUNIZATIONS**
PHYSICAL EXAMS	Not covered	100% after $5 per visit copayment	Not covered	100% after $5 per visit copayment	100% after $5 copayment per visit (1 visit per calendar year)	100%	100% after $5 per visit copayment	100% after $5 per visit copayment	**PHYSICAL EXAMS**
X-RAYS / LAB TESTS	80% after deductible; some charges paid at 100%	100% after $5 copayment per visit	70% after deductible	100% after $5 copayment per visit	100%	100%	100%	100%	**X-RAYS / LAB TESTS**
MATERNITY	Basic benefits at 100%; balance at 80% after deductible	$5 copayment for first prenatal office visit then 100% covered	70% after deductible	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	**MATERNITY**
WELL BABY	Not covered	100% after $5 per visit copayment	Not covered	100% after $5 per visit copayment	100% after $5 per visit copayment	100%	100% after $5 per visit copayment	100% after $5 per visit copayment	**WELL BABY**
ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox and rehab	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	**ALCOHOL ABUSE (INPATIENT)**
DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	**DRUG ABUSE (INPATIENT)**
ALCOHOL ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	**ALCOHOL ABUSE (OUTPATIENT)**
DRUG ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	**DRUG ABUSE (OUTPATIENT)**
MENTAL HEALTH (INPATIENT)[3]	100% for 20 days per calendar year; balance at 80% after deductible up to annual/lifetime maximums	100% up to 25 days per calendar year; balance at 90% up to annual/lifetime maximums	50 days per calendar year at 50% after deductible up to annual/lifetime maximums	100% up to 35 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	**MENTAL HEALTH (INPATIENT)[3]**
MENTAL HEALTH (OUTPATIENT)[3]	80% after deductible up to $10,000 annual/ $20,000 lifetime maximum	90% up to $15,000 annual/$50,000 lifetime maximum	70% after deductible up to $15,000 annual/$50,000 lifetime maximum	100% after $10 copayment per visit for up to 30 visits per calendar year	100% after $5 copayment per visit for up to 30 visits per calendar year	100% after $10 copayment per visit for up to 30 visits per calendar year	100% after $10 copayment per visit for up to 30 visits per calendar year	100% after $5 copayment per visit for up to 30 visits per calendar year	**MENTAL HEALTH (OUTPATIENT)[3]**
PHYSICAL / SPEECH THERAPY[4]	80% after deductible	100% after $5 per visit copayment	70% after deductible	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	**PHYSICAL / SPEECH THERAPY[4]**
HOME HEALTH CARE	Services and supplies covered with pre-approval; 60 visits in 61 days at 80%	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered; subject to out-of-network insurance and deductible	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered; 120 visit per calendar year maximum	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	Services and supplies covered with pre-approval; prior inpatient hospital stay not required; nursing home care or custodial care not covered	**HOME HEALTH CARE**
DISEASE MANAGEMENT[5]	Not applicable	Diabetes only	Diabetes only	Heart disease, asthma, diabetes, low back pain; Healthy Outlook Program available through your PCP - voluntary	Well Aware Program monitored by PCP for chronic conditions like low back pain, asthma, and diabetes	Voluntary program available for: Living with Diabetes; Better Breathing Asthma, Newborn Critical Care, Heart Smart Program, High Risk Maternity	Connections Program voluntary for asthma, diabetes, heart failure, joint replacements; talk to PCP for details	Voluntary program for diabetes, congestive heart diseases, asthma, coronary artery disease, emphysema, rare diseases, kidney disease and other chronic diseases; call (800) 573-2177	**DISEASE MANAGEMENT[5]**
PRIVATE DUTY NURSING	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Must be ordered by a doctor, provided by an RN or LPN; excludes care that can be provided by hospital staff or home health care aides; excludes assistance with daily activities	Inpatient hospital care excluded; outpatient care must be authorized by PCP and services rendered by or supervised by a RN; not covered unless medically necessary	Inpatient hospital care excluded; outpatient care must be authorized by PCP and services rendered by or supervised by a RN; not covered unless medically necessary	Inpatient hospital care excluded; outpatient care must be authorized by PCP and services rendered by or supervised by a RN; not covered unless medically necessary	Inpatient hospital care excluded; outpatient care must be authorized by PCP and services rendered by or supervised by a RN; not covered unless medically necessary	Inpatient hospital care excluded; outpatient care must be authorized by PCP and services rendered by or supervised by a RN; not covered unless medically necessary	**PRIVATE DUTY NURSING**
HOSPICE	100%	100%	70% after deductible	100%	100%	100%	100%	100%	**HOSPICE**
INFERTILITY SERVICES	Diagnosis covered; treatment covered with limitations; subject to a coinsurance and deductible	Must be pre-authorized; diagnosis covered; treatment covered with limitations	Call plan for pre-authorization; diagnosis covered; treatment covered with limitations; subject to out-of-network insurance and deductible	Must be pre-authorized; diagnosis covered; treatment covered with limitations	Must be pre-authorized; diagnosis covered; treatment covered with limitations	Must be pre-authorized; diagnosis covered; treatment covered with limitations	Must be pre-authorized; diagnosis covered; treatment covered with limitations	Must be pre-authorized; diagnosis covered; treatment covered with limitations	**INFERTILITY SERVICES**
RETIREE/EMPLOYEE SHARE OF COSTS									**RETIREE/EMPLOYEE SHARE OF COSTS**
DEDUCTIBLES (INDIVIDUAL)	$100 per calendar year (medical expenses only)	None	$100 per calendar year (most expenses); $200 per hospital admission	None	None	None	None	None	**DEDUCTIBLES (INDIVIDUAL)**
DEDUCTIBLES (FAMILY MAXIMUM)	Employee and/or retiree plus one dependent must meet individual deductible	None	$250 per calendar year (most expenses); $200 per hospital admission	None	None	None	None	None	**DEDUCTIBLES (FAMILY MAXIMUM)**
MAXIMUM OUT-OF-POCKET (INDIVIDUAL)	$400 per calendar year coinsurance + $100 deductible	$400 per calendar year (coinsurance only)	$2,000 per calendar year (coinsurance only)	No maximum	$1,500 per calendar year (sum of copayments)	No maximum	$650 per calendar year (sum of copayments)	$2,700 per calendar year (sum of copayments)	**MAXIMUM OUT-OF-POCKET (INDIVIDUAL)**
MAXIMUM OUT-OF-POCKET (FAMILY)	$400 X number of dependents + deductible	$1,000 per calendar year (coinsurance only)	$5,000 per calendar year (coinsurance only)	No maximum	$3,000 per calendar year (sum of copayments), then 100%	No maximum	$650 per person per calendar year (sum of copayments), then 100%	$5,400 per calendar year (sum of copayments), then 100%	**MAXIMUM OUT-OF-POCKET (FAMILY)**
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	$1,000,000 lifetime (major medical expense only); $10,000 annual mental health - $20,000 lifetime mental health; up to $2,000 restoration feature each year[3]	Unlimited; $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year[3]	$1,000,000 lifetime (major medical expense only); $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year[3]	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	**MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME**
PLAN AND TELEPHONE NUMBER	**#002 TRADITIONAL[1] 1-800-414-7427**	**#001 - NJ PLUS In-Network 1-800-414-7427**	**#001 - NJ PLUS Out-of-Network[1] 1-800-414-7427**	**#019 - AETNA Active 1-800- 309-2386 Retiree on Medicare 1-800-345-4432**	**#020 CIGNA HEALTHCARE 1-800-244-6224**	**#028 OXFORD 1-800-760-4566**	**#033 AMERIHEALTH 1-800-877-9829**	**#034 HEALTH NET[6] 1-800-441-5741**	**PLAN AND TELEPHONE NUMBER**

[1]Benefits, excluding hospital expenses, are based on the Horizon's PACE allowance or the "reasonable and customary" fee schedule at the 90% percentile.

[2]Most plans require notice to the PCP within 48 hours of the incident. Copayment waived if admitted.

[3]Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

[4]Speech therapy limited to: restoration after a loss or impairment of a demonstrated previous ability to speak; develop or improve speech after surgical correction of a birth defect.

[5]Most disease management programs provide educational materials, and in some cases, individualized case management for members with an emphasis on health education and behavior modification.

[6]Referral is not required from a PCP to a participating specialist.

NEW JERSEY
STATE HEALTH BENEFITS PROGRAM

COMPARISON SUMMARY FOR MEMBERS

Effective January 1, 2003

Department of the Treasury

Division of Pensions and Benefits

Dear Employees and Retirees:

The *State Health Benefits Program Comparison Summary* provides an easy way for employees and retirees to compare the benefits of the various plans offered by the State Health Benefits Program (SHBP) by summarizing what benefits each plan provides for a specified service.

For members wanting to know more about what their plan offers, this chart can be a handy quick reference guide to the services currently offered by your health plan. The *SHBP Comparison Summary* can also be a very useful tool if you are a new SHBP member or a SHBP member who is considering a different health plan. Although the chart contains a lot of information, using the following helpful hints can make reading this chart easier.

If you are looking for how a specific service is covered — locate the service that you are inquiring about in the left or right hand shaded columns, follow horizontally across the chart and compare how that particular service is covered by the various health plans. Determine which plan provides the best coverage for the services that you or your family may need.

If you are looking for general plan information offered by the SHBP — locate the name of the plan along the top row. The "Service Area", in the second row, lists what states and/or counties are covered under that particular plan. The specific services offered by that plan are listed vertically in the column under the plan name — this column should be cross-referenced with the left or right hand column of the chart, which contains a listing of the basic services.

If you are considering a managed care plan (an HMO or NJ PLUS) contact your doctor's office to see if they participate in any of those plans you have selected. You can also use the SHBP Unified Provider Directory available on the Internet *(see address below)*. The Unified Provider Directory lists current participating physicians for all of the SHBP plans.

MEDICARE AND THE SHBP

This comparison chart describes benefits available to members and their dependents. The benefits listed were selected as those most likely to be of interest to you. To be eligible for benefits supplemental to Medicare under the SHBP, both Parts A and B of Medicare must be obtained when retired members become eligible. The SHBP will not pay for benefits which should have been paid for by Medicare. For additional information see Fact Sheet #23, *The Traditional Plan and Medicare Parts A and B*.

IF MEDICARE IS YOUR PRIMARY PAYER

For the Traditional Plan and NJ PLUS out-of-network coverage, claims are first submitted to Medicare and then depending where services are provided, unreimbursed expenses may be sent to your SHBP plan by the Medicare carrier for further reimbursement. The member may still have out-of-pocket expenses such as deductibles and costs above reasonable and customary allowances.

Under HMOs and the in-network NJ PLUS plan, this coordination of benefits also occurs but is handled by the HMO or NJ PLUS provider and/or the plan, so that benefits and procedures remain the same for enrollees regardless of Medicare eligibility. Enrollees simply pay their normal co-payments to the provider. The deductibles and coinsurance required by Medicare will be paid in full by your health plan.

If the claim is one where our plan does not receive the claim information automatically, you must submit the claim directly to your plan along with a copy of the *Medicare Evidence of Insurability* statement.

For more information about the available health plans, or eligibility in the SHBP, see the *Summary Program Description* booklet. The *Summary Plan Description* is available from your employer, the Division of Pensions and Benefits, or over the internet at:

www.state.nj.us/treasury/pensions/shbp.htm

COMPARISON CHART

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

PLAN	#002 TRADITIONAL	#001 - NJ PLUS		#019 - AETNA #20 - CIGNA #033 - AMERIHEALTH #034 - HEALTH NET	#028 - OXFORD
		In-Network	Out-of-Network		
PRESCRIPTION DRUGS[7, 8] *Benefits for ACTIVE employees without employer prescription drug plan*	80% after deductible	90% reimbursement	70% after deductible	**Pharmacy:** 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Pharmacy: 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $15 Name brand - $30
PRESCRIPTION DRUGS[8] *RETIREES*	**Pharmacy:** 30-day supply Generic - copayment $6[9] Preferred brand - $11[9] Other brands - $23[9] **Mail Order:** 90-day supply Generic - $6[9] Preferred brand - $17[9] Other brands - $28[9]	**Pharmacy:** 30-day supply Generic - copayment $6[9] Preferred brand - $11[9] Other brands - $23[9] **Mail Order:** 90-day supply Generic - $6[9] Preferred brand - $17[9] Other brands - $28[9]	**Pharmacy:** 30-day supply Generic - copayment $6[9] Preferred brand - $11[9] Other brands - $23[9] **Mail Order:** 90-day supply Generic - $6[9] Preferred brand - $17[9] Other brands - $28[9]	**Pharmacy:** 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	**Pharmacy:** 30-day supply Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $15 Name brand - $30

PLAN	#002 TRADITIONAL	#001 - NJ PLUS	#019 - AETNA #20 - CIGNA #034 - HEALTH NET	#033 - AMERIHEALTH	#028 - OXFORD
DENTAL COVERAGE	None	None	None	Exams, cleaning, and fluoride treatments for members under age 12	Exams and cleaning for members under age 12

PLAN	#002 - TRADITIONAL #001 - NJ PLUS Out-of-Network	#001 - NJ PLUS In-Network #034 - HEALTHNET	#019 - AETNA	#20 - CIGNA	#033 - AMERIHEALTH	#028 - OXFORD
ROUTINE VISION EXAM	None	100% after $5 copayment; one exam per calendar year; no referral needed	100% after $5 copayment; exam every 1 to 3 years based on age; no referral needed	100% after $5 copayment; one exam per calendar year; referral required	100% after $5 copayment; one exam every 24 month period; must use specified vendor, no referral needed	$50 reimbursed toward routine exam per 12 month period

[7]If your employer provides a separate prescription drug plan to employees, the medical plan will not include any drug coverage. If no separate prescription drug plan is provided, the medical plan will provide drug coverage as noted.

[8]Certain prescription drugs may require precertification prior to purchase. Please contact your health plan for details.

[9]Maximum copayments per member are $397 per year.

Managed Care Plan Standards

The SHBP has established minimum coverage requirements and operating standards for all participating HMOs that safeguard our members and make it easier to compare and choose between plans. The following is not a benefit summary but a listing of benefit coverages for which the SHBP has imposed a mandatory expectation or requirement.

STANDARDS INCLUDE:

- All physician referrals will be valid for a minimum of 90 days from the date of authorization.
- Certain treatments requiring numerous visits (e.g., chemotherapy) shall not require repeated referrals.
- Member handbooks must include a Schedule of Benefits which will provide a list of covered services, benefit limitations and benefit exclusions, and appropriate definitions.
- The HMO will notify the State and members prior to any proposed changes in the provider network, including facilities, that alter member access to providers or services.
- There shall be no pre-existing condition restrictions.
- Network within network referral restrictions will not be permitted.
- Right to change Primary Care Providers must be permitted on at least a monthly basis.
- Scope of services covered under the well-woman OB/GYN provisions must be clearly defined, including the explicit services which must be authorized by the member's PCP. It is required that two or more well-woman OB/GYN examinations be available during the Benefit Plan Year, and that a well-woman mammogram not require a PCP authorization.
- HMO members must be permitted to self-refer to network mental health and substance abuse practitioners.
- Extension of health benefits must be made at no cost to totally disabled members who do not elect COBRA coverage and to those whose coverage terminates at the end of the COBRA continuation period including cessation of premium payments. The extension is made available to those members who are totally disabled on the date their coverage terminates and need not require hospital confinement, and is only applicable to expenses incurred in the treatment of the disabling condition. The extension period will end on the earliest of:
  - the date the total disability ends;
  - one year from the date the person's coverage under the SHBP ends;
  - the date the person has received the maximum benefits under the HMO's Plan for the disabling condition; or
  - the person becomes covered under any replacement plan established by the employer.

EMERGENCY

1. The following definition for emergency care will be adhered to by all plans:

   Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

   a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

   b) serious impairment to bodily function; or

   c) serious dysfunction of any bodily organ or part.

   There will be a $35 maximum copayment for emergency room services; waived if admitted.

2. With respect to emergency services furnished in a hospital emergency department, a health plan shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson, regardless of whether the hospital was affiliated with the Health Maintenance Organization. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by the Health Maintenance Organization.

MINIMUM COVERAGE REQUIREMENTS

Benefit standards include:

- Routine office visit copayments will be $5.
- All plans will cover chiropractor visits up to a maximum of 20.
- $100 will be the maximum annual copayment for medical appliances and durable equipment.
- Hair prosthesis furnished in connection with hair loss resulting from the treatment of disease by radiation or chemicals will be covered.
- Routine inoculations for adults (not related to travel or occupation) will be covered.
- The cost of care to organ transplant donors will be covered. (Coordination of benefits will apply.)
- Admissions at skilled nursing homes will be covered up to 120 days.
- Hospice services will be covered in full.
- Home health care will be covered up to a minimum of 120 visits.
- Outpatient therapy will be covered up to 60 consecutive visits per condition.
- Repair and replacement of prosthesis will be covered.
- Surgical leggings will be covered if medically necessary.
- There will be no reimbursement for vision hardware.

MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE

- There will be no copayment charged for outpatient drug and alcohol rehabilitation treatment.
- All plans will use standard treatment criteria established by the American Society of Addictive Medicine (ASAM).
- Coverage for outpatient mental health services will be at a minimum 30 visits and a maximum copayment of $10.
- Following a detoxification patients are entitled to 28 days of inpatient rehabilitation per occurrence.

Comparison of Health Maintenance Organizations

from the Department of Health and Senior Services 2001 NJ HMO Performance Report

PLAN NAME	SERVICE AND ACCESS	DOCTORS AND MEDICAL CARE	STAYING HEALTHY	GETTING BETTER/LIVING WITH ILLNESS
Aetna Health	●	●	●	●
AmeriHealth	●	●	●	◓
CIGNA HealthCare	◓	○	●	◓
Oxford Health Plan	◓	◓	●	●
Health Net	◓	◓	◓	○

Performance Compared to the Average

● **Higher** than the New Jersey health plan average

◓ **About the Same** as the New Jersey health plan average

○ **Lower** than the New Jersey health plan average

For rating details see the

2001 New Jersey HMO Performance Report: Compare Your Choices

2002 report to be released in October, 2002

HA-0371-0802

Visit us on the Internet at

http://www.state.nj.us/treasury/pensions/shbp.htm

or e-mail us at

E-mail: SHBP_NJ@tre.state.nj.us

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